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1. Inpatient hospital services other than those provided in an institution for mental diseases.

   Described in Attachment 4.19-A

2. Payments for Medicare Part A inpatient deductible.

   Described in Attachment 4.19-A (Rates will be paid in strict accordance with the State Plan under 4.19-A)

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2.a OUTPATIENT HOSPITAL SERVICES

With respect to hospitals licensed by the State of North Carolina that are qualified to certify public expenditures, and do certify, in accordance 42 CFR 433.51(b), other than hospitals that are State-owned and operated by the Department of Health and Human Services, all primary affiliated teaching hospitals for the University of North Carolina Medical Schools and Critical Access Hospitals pursuant to 42 USC 1395i-4, the expenditures claimable for Federal Financial Participation (FFP) will be the hospitals' reasonable costs incurred in serving Medicaid outpatients, as determined in accordance with Medicare principles. Each hospital's allowable Medicaid outpatient costs for the rate year will be determined on an interim basis by multiplying the hospital's Medicaid outpatient ratio of cost-to-charges (RCCs) as specified on lines 37-68 of Worksheet C or D from the hospital's most recent available as-filed CMS 2552 cost report by the hospital's allowable Medicaid outpatient charges for services provided during the same fiscal year as the cost report and paid within nine months after the end of that same fiscal year. This cost data will be brought forward to the end of the period for which FFP is being claimed by applying the applicable CMS PPS Hospital Input Price Indices. Hospitals' final allowable costs of serving Medicaid outpatients will be determined using audited CMS 2552 cost reports for the year for which final FFP is being determined. The difference between the final and interim allowable Medicaid cost will be an adjustment(s) to the applicable period for which the cost was incurred and initial claim was made. This paragraph is valid through September 30, 2006.

All hospitals that are state-owned and operated by the Department of Health and Human Services, all primary affiliated teaching hospitals for the University of North Carolina Medical Schools and Critical Access Hospitals pursuant to 42 USC 1395i-4 will be reimbursed their allowable outpatient costs as determined using the CMS 2552 in accordance with the provisions of the Medicare Provider Reimbursement Manual. All other hospitals will be reimbursed 80 percent of their allowable outpatient costs as determined using the CMS 2552 cost report and in accordance with the Medicare Provider Reimbursement Manual. Hospitals that are not qualified to certify public expenditures will also be paid using the enhanced payments for outpatient services methodologies described below.

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PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

2.a.1. ENHANCED PAYMENTS FOR OUTPATIENT HOSPITAL SERVICES

Hospitals that are licensed by the State of North Carolina and are not qualified to certify public expenditures, shall be entitled to enhanced payments, for outpatient services for the 12-month period ending September 30 of each year, paid annually in up to four installments.

(1) The enhanced payment shall equal a percent, not to exceed the State's federal financial participation rate in effect for the period for which the payment is being calculated, of the hospital's outpatient "Medicaid deficit." At least 10 calendar days in advance of the first payment of the payment plan year, the Division will determine, and notify eligible hospitals of, the percent of the outpatient "Medicaid deficit" to be paid as the enhanced payment for outpatient services.

(2) The "Medicaid deficit" is calculated as follows:

A. Reasonable costs of outpatient hospital Medicaid services shall be determined annually by calculating a hospital's Medicaid outpatient cost-to-charge ratio using the most recent available as-filed hospital fiscal year CMS 2552 cost report data available before payments are calculated and multiplying the Medicaid outpatient cost-to-charge ratio by the hospital's Medicaid allowable charges for outpatient services provided during the same fiscal year as the filed cost report and paid within nine months after the end of the fiscal year .

B. Applying an inflation factor calculated based on the most current information available at the time on the CMS website for the CMS PPS Hospital Input Price Index to bring the cost data forward to the end of the payment period.

C. Multiplying the Medicaid outpatient costs by 20 percent.

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(3) Payments calculated under Paragraph 2.a.1.(when added to other Medicaid payments received or to be received for these services) shall not cause aggregate payments to any category of hospitals as specified in 42 CFR 447.321 to exceed the maximum allowed aggregate upper limits for that category established by applicable federal law and regulation.

(4) The payments authorized under Paragraph (e) shall be effective in accordance with GS 108A-55(c).

(5) This ENHANCED PAYMENTS FOR OUTPATIENT HOSPITAL SERVICES is valid through September 30, 2006.

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2.a.2. ENHANCED PAYMENTS TO TEACHING HOSPITALS FOR OUTPATIENT HOSPITAL SERVICES

Hospitals that are not qualified to certify, are licensed by the State of North Carolina, qualify for disproportionate share hospital status under Paragraph (c) of the Disproportionate Share Hospital payment section of this plan, and, for the fiscal year immediately preceding the period for which payments under this Paragraph are being calculated:

i. Qualify to receive inpatient hospital rate adjustment payments described in Paragraph (g) of the section of this plan entitled "INPATIENT HOSPITAL RATE ADJUSTMENT PAYMENT TO HOSPITALS SERVING HIGH PORTIONS OF LOW INCOME PATIENTS;" and

ii. Operate at least two Medicare approved graduate medical education programs and report on cost reports filed with the Division, Medicaid costs attributable to such programs;

shall be entitled to additional enhanced payments for outpatient services, paid annually in up to four installments.

(1) The additional enhanced payment for Medicaid outpatient services shall satisfy the portion of the outpatient "Medicaid deficit" equal to 7.22 percent of the hospital's estimated uncompensated care cost of providing inpatient and outpatient services to uninsured patients

(2) The outpatient "Medicaid deficit" shall be calculated as follows:

A. Reasonable costs of outpatient hospital Medicaid services shall be determined annually by calculating a hospital's Medicaid outpatient cost-to-charge ratio using the most recent available as-filed CMS 2552 cost report data and multiplying the Medicaid outpatient cost-to-charge ratio by the hospital's Medicaid allowable charges for outpatient services provided during the same fiscal year as the filed cost report, but paid within nine months after the end of the fiscal year,

B. Applying the applicable CMS PPS Hospital Input Price Indices to bring the cost data forward to the end of the payment period.

C. Multiplying the Medicaid outpatient costs by 20 percent.

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(3) Uncompensated care costs are calculated using hospitals' gross charges for services provided to uninsured patients as filed with and certified to the Division for the same fiscal year as the CMS cost report used in determining reasonable cost in 2. A. above. The Division shall convert hospitals' gross charges for uninsured patients to costs by multiplying them by a cost-to-charge ratio determined using hospitals' most recent available as-filed CMS 2552 cost reports for the same fiscal year used in 2.A. and then subtracting payments hospitals received from uninsured patients.

(4) Payments under Paragraph 2.a.2.(when added to Medicaid payments received or to be received for these services) shall not cause aggregate payments to any category of hospitals as specified in 42 CFR 447.321 to exceed the maximum allowed aggregate upper limits for that category established by applicable federal law and regulation.

(5) The payments authorized under Paragraph 2.a.1. and 2.a.2. shall be effective in accordance with GS 108A-55(c).

(6) This ENHANCED PAYMENTS TO TEACHING HOSPITALS FOR OUTPATIENT HOSPITAL SERVICES is valid through September 30, 2006.

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2.b. Rural health clinic (RHC) services and other ambulatory services furnished by a rural health clinic. Subparagraph (1) through (5) conform to the provisions of the Benefits Improvement and Protection Act of 2000.

(1) Effective for dates of service occurring January 1, 2001 and after, RHCs are reimbursed on a prospective payment rate. The initial rate is equal to 100 per cent of their average reasonable costs of Medicaid covered services provided during the clinic's fiscal years 1999 and 2000, adjusted to take into account any increase (or decrease) in the scope of services furnished during fiscal year 2001 by the RHC (calculating the payment amount on a per visit basis).

(A) In determining the initial PPS rate, cost caps for core services shall continue to be used to determine reasonable cost, as established by Medicare.

(B) The clinic's average fiscal years 1999 and 2000 cost shall be calculated by adding the total reasonable costs together for fiscal year 1999 and fiscal year 2000 and dividing by the number of visits.

(C) A visit means a face-to-face encounter between an RHC patient and any health professional whose services are reimbursed under the State Plan.

(D) In the case of any RHC with a managed care organization, supplemental payments will be made no less frequently than every four months to the clinic for the difference between the payment amounts paid by the managed care organization and the amount to which the clinic is entitled under the prospective payment system.

(2) At the beginning of each clinic's fiscal year, subsequent to January 1, 2001, the rates shall be increased by the percentage increase in the Medicare Economic Index for primary care services and adjusted to take into account any increase (decrease) in the scope of services furnished during that fiscal year.

(A) A rate adjustment due to change in the scope of services must be supported by the preponderance of evidence by the provider.

(B) The Division of Medical Assistance shall make rate adjustments due to change in the scope of services.

(C) The MEI rate adjustment shall take effect on the first day of the provider's fiscal year.

(D) Rates may also be adjusted to take into consideration reasonable changes in the industry's cost of service.

(3) Newly qualified RHCs after December 31, 2000, will have their initial rates established either by reference to rates paid to other clinics in the same or adjacent areas with similar caseload, or in the absence of such other clinics, through cost reporting methods. Rates for subsequent fiscal years shall be based on the same update methods reflected in subparagraph (2) above.

(4) Notwithstanding the above, interim fiscal year 2001 rates shall be the rates currently in effect on December 31, 2000, since information needed to establish rates per subparagraph (1) is not currently available.

(A) These rates shall be adjusted annually in accordance with subparagraph (2) of this paragraph.

(B) These rates shall be adjusted based on available as filed cost reports, in accordance with subparagraph (1) of this paragraph.

(C) These rates shall be settled and reconciled back to January 1, 2001 in order to establish the permanent prospective rates determined in accordance with subparagraph (1) once audited cost reports become available.

(5) Providers who elected to be reimbursed in accordance to the cost based methodology in effect on December 31, 2000, and who did not change their election prior to January 1, 2005 shall remain with that choice of cost based reimbursement methodology.

(A) Rates paid under this cost based reimbursement methodology must be at least equal to the payment under the payment methodology included in subparagraphs (1) and (2). To ensure providers receive no less under the cost based reimbursement methodology than under PPS, the actual amount received under cost based reimbursement is compared to the amount a provider would have received under PPS.

(B) Provider clinics are paid on the basis of the principles and at the Medicare determined rates specified in the Medicare regulation in Part 405, Subpart D not to exceed the Medicare established limits. For Medicaid only services, the interim rates are based on a Medicaid fee schedule.

(C) Independent clinics are paid for all core services offered by the clinic at a single cost-reimbursement rate for clinic visit, established by the Medicare carrier, which includes the cost of all core services furnished by the clinic.

(D) Effective October 1, 1993, physician-provided services at a hospital inpatient or an outpatient location are paid at the existing fee-for-service rate only to those clinics whose agreement with their physician states that the clinic does not compensate the physician for services in a location other than at the rural health clinic location.

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

2.c. Federally qualified health center (FQHC) services and other ambulatory services furnished by a federally qualified health center. Subparagraph (1) through (5) conform to the provisions of the Benefits Improvement and Protection Act of 2000.

(1) Effective for dates of service occurring January 1, 2001 and after, FQHCs are reimbursed on a prospective payment rate. The initial rate is equal to 100 per cent of their average reasonable costs of Medicaid covered services provided during the center's fiscal years 1999 and 2000, adjusted to take into account any increase (or decrease) in the scope of services furnished during fiscal year 2001 by the FQHC (calculating the payment amount on a per visit basis).

(A) In determining the initial PPS rate, cost caps for core services shall continue to be used to determine reasonable cost, as established by Medicare.

(B) The center's average fiscal years 1999 and 2000 cost shall be calculated by adding the total reasonable costs together for fiscal year 1999 and fiscal year 2000 and dividing by the number of visits.

(C) A visit means a face-to-face encounter between an FQHC patient and any health professional whose services are reimbursed under the State Plan.

(D) In the case of any FQHC with a managed care organization, supplemental payments will be made no less frequently than every four months to the center for the difference between the payment amounts paid by the managed care organization and the amount to which the center is entitled under the prospective payment system.

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(2) At the beginning of each center's fiscal year, subsequent to January 1, 2001, the rates shall be increased by the percentage increase in the Medicare Economic Index for primary care services and adjusted to take into account any increase (decrease) in the scope of services furnished during that fiscal year.

(A) A rate adjustment due to change in the scope of services must be supported by the preponderance of evidence by the provider.

(B) The Division of Medical Assistance shall make rate adjustments due to change in the scope of services.

(C) The MEI rate adjustment shall take effect on the first day of the provider's fiscal year.

(D) Rates may also be adjusted to take into consideration reasonable changes in the industry's cost of service.

(3) Newly qualified FQHCs after December 31, 2000, will have their initial rates established either by reference to rates paid to other centers in the same or adjacent areas
with similar caseload, or in the absence of such other centers, through cost reporting methods. Rates for subsequent fiscal years shall be based on the same update methods reflected in subparagraph (2) above.

(4) Notwithstanding the above, interim fiscal year 2001 rates shall be the rates currently in effect on December 31, 2000, since information needed to establish rates per subparagraph (1) is not currently available.

(A) These rates shall be adjusted annually in accordance with subparagraph (2) of this paragraph.

(B) These rates shall be adjusted based on available as filed cost reports, in accordance with subparagraph (1) of this paragraph.

(A) These rates shall be settled and reconciled back to January 1, 2001 in order to establish the permanent prospective rates determined in accordance with subparagraph (1) once audited cost reports become available.

(5) Providers who elected to be reimbursed in accordance to the cost based methodology in effect on December 31, 2000, and who did not change their election prior to January 1, 2005 shall remain with that choice of cost based reimbursement methodology.

(A) Rates paid under this cost based reimbursement methodology must be at least equal to the payment under the payment methodology included in subparagraphs (1) and (2). To ensure providers receive no less under the cost based reimbursement methodology than under PPS, the actual amount received under cost based reimbursement is compared to the amount a provider would have received under PPS.

(B) Services furnished by a federally qualified health center (FQHC) are reimbursed at one hundred percent (100%) of reasonable cost, not to exceed the Medicare established limits, as determined in an annual cost report, based on Medicare principles and methods (for Medicaid only services, the interim rates are based on a Medicaid fee schedule) when:

(1) It is receiving a grant under Section 329 (migrant health centers), 330 (community health centers) or 340 (health care centers for the homeless), Public Housing Health Centers receiving grant funds under Section 340A of the Public Health Service Act and Urban Indian organizations receiving funds under Title V of the Indian Health Improvement Act are FQHC's effective calendar quarter beginning or after October 1, 1993;

(2) It meets the requirements for receiving a Public Health Service grant or was treated as a comprehensive federally funded health center as of January 1, 1990.

(3) Nutrition services are provided by rural health centers and FQHC. Providers are reimbursed in accordance with reimbursement methodologies established for services provided by rural health clinics and FQHCs as based on Medicare principles.

(4) Effective October 1, 1993, physician-provided services at a hospital inpatient and an outpatient location are paid at the existing fee-for-service rate only to those clinics whose agreement with their physician states that the clinic does not compensate the physician for services in a location other than at the federally qualified health clinic location.

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3. Other Laboratory and X-ray Services

Fees for independent laboratory services shall be the lower of the submitted charge or the appropriate fee from the fee schedule in effect on July 1, 1990.

a. Annual fees are increased each January 1, based on the forecast of the Gross National Product (GNP) implicit price deflator, but not to exceed the percentage increase granted by the N.C. State Legislature and not to exceed the Medicare maximum fees.

b. Fees for new services are established based on fees for similar existing services. If there are no similar services the fee is set at the Medicare maximum fee. If there is no Medicare fee available, the fee is established at 60 percent of charges until a Medicare fee is established.

The above methodology shall also apply to laboratory services paid to hospital outpatient facilities, physicians, and any provider supplying outpatient laboratory services.

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PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

4.a. Skilled nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Described in 4.19-D

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4.b. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.

For providers other than individual practitioners a negotiated encounter rate is not to exceed reasonable cost. This rate shall also serve as the upper limit for reimbursement for individual practitioners providing the same services.

Services contained in 1905(a) and not listed as covered services in the state agency manuals/state plan will be provided. Services provided as described in Section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by screening services and not covered in the state plan will be provided if determined to be medically necessary by the appropriate agency staff or consultants. The reimbursement rate for these services will be at statewide usual and customary fees. If the provider is a government agency and/or a non-profit organization, the reimbursement will be no greater than actual costs. This is in compliance with 45 CFR Subpart Q.

Additional service categories are reimbursed as follows:

Other Diagnostic Screening, Preventive and Rehabilitative Services are reimbursed in accordance with Attachment 4.19-B, Section 13, page 1.

Clinic services are reimbursed in accordance with Attachment 4.19-B, Section 9, page 1.

Hospital Outpatient services are reimbursed in accordance with Attachment 4.19-B, Section 2, page 1

Nutrition services will be reimbursed in accordance with reimbursement methodologies as based on negotiated fee not to exceed reasonable cost.

Hearing aids and hearing aid accessories are reimbursed at invoice cost (invoices must accompany claims for aids and accessories). Fitting and dispensing services are reimbursed at a fixed reasonable reimbursement fee.

Batteries are reimbursed at current retail costs; an invoice is not required and a dispensing fee is not allowed.

Payment is based on negotiated fee not to exceed reasonable cost.

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Home Health Agencies are reimbursed in accordance with Attachment 4.19-B, Section 7,
pages 1-5.

Physician services are reimbursed in accordance with Attachment 4.19-B, Section 5,
pages 1-21.

The agency assures that if there are providers involved whose payment is based on reasonable cost, the State will provide appropriate cost reimbursement methodologies.

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4.c. Family planning services and supplies for individuals of child bearing age.

Payment to Health Department Family Planning Clinics shall be on the basis of a
negotiated fee not to exceed average cost on a facility-by-facility basis.

For other providers see specific services, e.g. physicians, hospitals.

State Plan Under Title XIX of the Social Security Act
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5. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

PHYSICIAN'S FEE SCHEDULE

(a) Effective September 1, 2001, physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere, shall be reimbursed based on the North Carolina Medicaid Fee Schedule which is based on 95 percent of the Medicare Fee Schedule Resource Based Relative Value System (RBRVS) in effect on the date of service, except for payments to the various Medical Faculty Practice Plans of the University of North Carolina – Chapel Hill and East Carolina University which shall be cost settled at year end; but with the following clarifications and modifications:

(1) A maximum fee is established for each service and is applicable to all specialties and settings in which the service is rendered. Payment is equal to the lower of the maximum fee or the provider's customary charge to the general public for the particular service rendered.

(2) Fees for services deemed to be associated with adequacy of access to health care services may be increased based on administrative review. The service must be essential to the health needs of the Medicaid recipients, no other comparable treatment available and a fee adjustment must be necessary to maintain physician participation at a level adequate to meet the needs of Medicaid recipients.

(3) Fees for new services are established based on this Rule, utilizing the most current RBRVS, if applicable. If there is no relative value unit (RVU) available from Medicare, fees shall be established based on the fees for similar services. If there is no RVU or similar service, the fee shall be set at 75 percent of the provider's customary charge to the general public. For codes not covered by Medicare that Medicaid covers, annual changes in the Medicaid payments shall be applied each January 1 and fee increases shall be applied based on the forecasted Gross National Product (GNP) Implicit Price Deflator. Said annual changes in the Medicaid payments shall not exceed the percentage increase granted by the North Carolina State Legislature.

(4) For codes not covered by Medicare that Medicaid covers, a code may also be decreased, based on administrative review, if it is determined that the fee may exceed the Medicare allowable amount for similar services, or if the fee is higher than Medicaid fees for similar services, or if the fee is too high in relation to the skills, time, and other resources required to provide the particular service.

(5) Notwithstanding any other provision, if specified, these rates will be adjusted as shown on Attachment 4.19-B, Supplement 3, Page 1 of the State Plan.

(b) This reimbursement limitation shall become effective in accordance with the provisions of G.S. 108A-55(c). These changes to the Physician's Fee Schedule allowables shall become effective when the Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, approves amendment to CMS by the Director of the Division of Medical Assistance on or about September 1, 2001 as #MA 01-18, wherein the Director proposes amendments of the State Plan to amend the Physician's Fee Schedule.

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NOTE: *Information previously located on this page can be found at Attachment 4.19-B, Section 6.*

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6a-d. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law (podiatrists' services, optometrists' services, chiropractor services, and other practitioner services).

(1) CPT code rates for these licensed practitioners are adjusted annually in accordance with the physician services. A maximum fee is established for each service and is applicable to all specialties and setting in which the service is rendered. Payment is equal to the lower of the maximum fee or the provider's customary charge to the general public for the particular service rendered. This plan applies to other medical practitioners, such as chiropractors, optometrists, podiatrists, and nurse practitioners.

(2) The following licensed practitioners will have the following reductions to their maximum fee of the physician fee schedule rate.

(a) Certified Nurse Practitioners will receive 85%,
(b) Licensed Clinical Social Workers will receive 75%,
(c) Licensed Professional Counselors will receive 75%,
(d) Licensed Marriage and Family Therapists will receive 75%,
(e) Certified Nurse Specialists will receive 85%,
(f) Certified Psychological Associates will receive 75%,
(g) Certified Clinical Addictions Specialists will receive 75%, and
(h) Certified Clinical Supervisors will receive 75%.

(3) Any mental health non-CPT codes service which is available for other practitioners to bill will have its rate established based on Attachment 4.19-B, Section 13.

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(4) Annual fee increases are applied each January 1 based on the physician fee schedule adjustments as set out in Attachment 4.19-B, Section 5, but not to exceed the percentage increase approved by the North Carolina State Legislature.

(5) Fee for new services are established based on the fees for similar existing services. If there are no similar services the fee is established at 75% of estimated average charge.

(6) Fees for particular services can be increased based on administrative review if it is determined that the service is essential to the health needs of Medicaid recipients, that no alternative treatment is available, and that a fee adjustment is necessary to maintain physician participation at a level adequate to meet the needs of Medicaid recipients. A fee may also be decreased based on administrative review if it is determined that the fee may exceed the Medicare allowable amount for the same or similar services, or if the fee is higher than Medicaid fees for similar services, or if the fee is too high in relation to the skills, time and other resources required to provide the particular service.

(7) Payment to the Local Education Agencies for services provided are based on the physician fee schedule methodology as outlined in Attachment 4.19-B, Section 5. These rates are adjusted January 1st of each year.

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7. HOME HEALTH SERVICES

Services provided by Medicare certified home health agencies participating in the North Carolina Medicaid Program are to be reimbursed on a prospective payment basis as set forth in this plan. Qualified providers of Durable Medical Equipment (and DME associated supplies) and Home Infusion Therapies are paid on the basis of reasonable charges as defined in Section 7B and C, respectively. The intent of this plan is to develop reasonable rates that provide incentives for the cost effective and efficient delivery of home health services.

A. REIMBURSEMENT METHODS FOR CERTIFIED HOME HEALTH AGENCIES

(a) A maximum rate per visit is established annually for each of the following services:
- (1) Registered or Licensed Practical Nursing Visit;
- (2) Physical Therapy Visit;
- (3) Speech Therapy Visit;
- (4) Occupational Therapy visit;
- (5) Home Health Aide Visit.

(b) The maximum rate for the services identified in Section (a) above are computed and applied as follows:

(1) Payment of claims for visits is based on the lower of the billed customary charges or the maximum rate of the particular service. Governmental providers with nominal charge may bill at cost. For this purpose, a charge that is less than 50 percent of cost is considered a nominal charge. For such governmental providers, the payment amount is equal to the lower of the cost as billed or the applicable maximum rate.

(2) Maximum per visit rates effective July 1, 1996 for Registered or Licensed Practical Nursing, Physical Therapy, Speech Therapy, and Occupational Therapy shall be equal to the rates in effect on July 1, 1995.

(i) To compute the annual maximum rates effective each July 1 subsequent to July 1, 1996, The maximum rates per visit are adjusted as described in Sections (4), (5), and (6).

(3) Maximum per visit rate effective July 1, 1996 for Home Health Aide shall be equal to the rate in effect on July 1, 1995.

(i) To compute the annual maximum rates effective each July 1 subsequent to July 1, 1996, the fiftieth percentile cost per visit calculated from the base year 1994 cost reports is adjusted as described in Sections (4), (5), and (6).

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(4) Each year maximum rates are adjusted by an annual cost index factor. The cost index has a labor component with a relative weight of 75 percent and a non-labor component with a relative weight of 25 percent. The relative weights are derived from the Medicare Home Health Agency Input Price Index published in the Federal Register dated May 30, 1986. Labor cost changes are measured by the annual percentage change in the average hourly earnings of North Carolina service wages per worker. Non-labor cost changes are measured by the annual percentage change in the GNP Implicit Price deflator.
(5) The annual cost index equals the sum of the products of multiplying the forecasted labor cost percentage change by 75 percent and multiplying the forecasted non-labor cost percentage change by 25 percent. For services included under Section 2 the July 1, 1996 effective rates are multiplied by the cost index factor for each subsequent year up to the year in which the rates apply. For services included under Section 3 (i) base year costs per visit are multiplied by the cost index factor for each subsequent year up to the year in which rates apply.
(6) Other adjustments may be necessary for home health services to comply with federal or state laws or rules.

(c) Medical supplies except those related to provision and use of Durable Medical Equipment are reimbursed at the lower of a provider's billed customary charges or a maximum amount determined for each supply item. Fees will be established based on average, reasonable charges if a Medicare allowable amount cannot be obtained for a particular supply item. Estimates of reasonable cost will be used if a Medicare allowable amount cannot be obtained for a particular supply or equipment item. The Medicare allowable amounts will be those amounts available to the Division of Medical Assistance as of July 1 of each year. Fees for medical supplies deemed to be associated with adequacy of access to health care services are reviewed annually in relation to Medicare rates and may be increased through an as needed administrative review, resulting from client concerns. This administrative review entails the performance of a cost study with providers, averaging the providers' costs and setting the rate at that average amount. The service must be essential to the health needs of the Medicaid recipients, no other comparable treatment available, and a fee adjustment must be necessary to maintain provider participation at a level adequate to meet the needs of Medicaid recipients.

(d) Notwithstanding any other provision, if specified these rates will be adjusted as shown on Supplement 1 to the Attachment 4.19-B section of the state plan.

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APPEALS

Providers may appeal maximum rates by presenting written requests and supporting data. Rates will not be adjusted retroactively. Appeals will be processed in accordance with Division procedures for Provider Reimbursement Reviews.

COST REPORTING AND AUDITING

Annual cost reporting is required in accordance with the Medicare principles of reimbursement.

PAYMENT ASSURANCES

(a) The State will pay the amounts determined under this plan for each covered service furnished in accordance with the requirements of the State Medicaid Plan, provider participation agreement, and Medicaid policies and procedures. The payments made under this methodology will not exceed the upper limits as established by 42 C.F.R. 447.325.

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(b) Participation in the program is limited to providers who accept, as payment in full, the amounts paid in accordance with this plan.

(c) In all circumstances involving third party payment, Medicaid is the payor of last resort. Any amounts paid by non-Medicaid sources are deducted in determining Medicaid payment. For patients with both Medicare and Medicaid coverage, Medicaid payment is limited to the amount of Medicare-related deductibles and/or coinsurance for services, supplies and equipment covered under the Medicare program.

(d) Excess payments may be recouped from any provider found to be billing amounts in excess of its customary charges, or costs if charges are nominal.

B. DURABLE MEDICAL EQUIPMENT

Eff. 8/1/91

(a) Payment for each claim for durable medical equipment and associated supplies shall be equal to the lower of the supplier's usual and customary billed charges or the maximum fee established for each item of durable medical equipment or related supply. The maximum fees are set at the Medicaid fee schedule in effect on July 1, 1991. Fees for added equipment shall be at Medicare Part B Fees. If a Medicare fee can not be obtained for added equipment, then the fee shall be based on an estimate of reasonable cost. The maximum allowable fee shall be updated each August 1 based on the Gross National Product (GNP) implicit price deflator. Notwithstanding any other provision, if specified these rates will be adjusted as shown on Attachment 4.19-B, Supplement 2, Page 1 of the state plan. [The maximum allowable fee may be adjusted for any changes resulting from market and cost analysis conducted by the Division of Medical Assistance.] There shall be no retroactive payment adjustments for fee changes.

(b) Each equipment item shall be assigned to one of the following categories of payment methods:

(1) Purchase fee paid for inexpensive, routinely purchased, and customized equipment, and DME Supplies.

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(2) Monthly rental paid up to purchase price but for no more than 15 continuous months. Monthly rental is paid for other types of equipment when the initial expected medical needs is less than six (6) months, but not to exceed the purchase price if need extends beyond six months. Equipment with an initial expected medical need of six months or more may be paid as a purchase or a rental.

(3) Monthly rental payment for oxygen and oxygen equipment without any limitations.

(4) Servicing and repair fees shall be established for appropriate items. Through a prior approval process, recipient owned equipment is repaired on an "as needed basis if the repair estimate is less than the cost of replacement and if the equipment has not gone beyond its established life expectancy. Service contracts are not covered and manufacturer's warranties are expected to be honored when appropriate. Rental equipment repairs are not reimbursed separately but are considered to be covered in the monthly rental fee.

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The percentage increase approved by the North Carolina Legislature is developed by the Division of Medical Assistance and presented to the Legislature. It is an estimate of reasonable increases in our area and is calculated using the Gross National Product Implicit Price Deflator and local forecasts of medical equipment costs from the State Budget Office.

Equipment with an initial expected medical need of six months or more may be paid as purchase or rental clarification: When the need is projected at six months or more, the equipment may be purchased initially, or it may be rented until the purchased price is met, at which time it is considered purchased.

Estimates of reasonable costs are determined thru the use of a current ratio of fees to charge data established from paid claims files. This ratio is applied to average current charges as received from local providers.

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C. HOME INFUSION THERAPY

In-home parental and enteral therapies are reimbursed at the lower of billed customary charges or the comparable Medicare Part B allowable amount in effect as of February 1 of each year. If comparable Medicare fees are not available, fees will be based on average charges and updated each February 1 based on the forecast of the Gross National Produce Implicit Price Deflator. Notwithstanding any other provision, if specified these rates will be adjusted as shown on Attachment 4.19-B, Supplement 1, Page 2 of the state plan.

Payment for home IV drug therapies is made at 100 percent of the lesser of the actual charge or the applicable per diem fee schedule allowance. Drug prices will be established in accordance with the Pharmacy Plan in Section 12 of Attachment 4.19-B.

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Three separate fee schedule amounts are calculated; one for pain management, one for chemotherapy, and one for antibiotics and other drug therapies. The per diem for each type of drug therapy is the sum of the per diem allowances for each of five service components. The components and per diem calculations are:

1) Pharmacy Services: the per diem allowance for pharmacy services for each type of drug therapy is calculated using average hourly salaries and benefits for pharmacists multiplied by the estimated average hours per day spent for each drug in preparation.

2) Pharmacy Supplies: the per diem allowance for pharmacy supplies for each type of drug therapy is calculated using average prices for supplies associated with the preparation and dispensing of a single dose of each IV therapy multiplied by the average number of doses per day.

3) Pharmacy Delivery: the per diem allowance for pharmacy delivery for each type of drug is calculated by adding a per trip non-labor and labor calculation. Then adding fifty percent for overhead.

   The non-labor portion is calculated using an estimated average mileage per trip multiplied by the federal mileage allowance. The labor portion is calculated by multiplying an estimated travel time for each delivery by an estimated salary and benefits for a delivery person. The per trip delivery calculation is then multiplied by the estimated number of trips per day for each type of drug.

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4) Nursing Services and Supplies: the per diem for nursing services and supplies for each type of drug therapy is calculated using the nursing visit payment for a skilled nurse from the Home Health Fee schedule described in Section 7 of Attachment 4.19-B, multiplied by an average number of weekly visits for each type of therapy then divided by seven.

The per diem for nursing supplies is calculated using an estimate of average prices for supplies associated with nursing services.

In the case of amphotericin therapy, an additional hourly payment will be made for all hours exceeding two hours per visit. This payment will be made at the home health hourly fee for a private duty nurse as described in Section 7 of Attachment 4.19-B. The additional payment will be provided for other drug therapies upon specific approval by the Division of Medical Assistance.

5) Equipment: the per diem for equipment is calculated using the separate fee schedule amount from the parental and enteral fee schedule that is paid for equipment necessary for IV therapies.

In those cases where a patient is receiving more than one type of IV drug simultaneously, the primary therapy will be reimbursed at an add-on per diem allowance calculated at 50 percent of the pharmacy services per diem, 100 percent of pharmacy supplies per diem, 50 percent of the pharmacy services per diem, 100 percent of pharmacy supplies per diem, 50 percent of the nursing supplies per diem, and 100 percent of the equipment per diem. The drug with the higher per diem is considered the primary. If a patient's drug regimen changes or the patient dies after a pharmacy delivery has been made but before usage of the entire drug issued the average of the per diem's for pharmacy services, pharmacy supplies and pharmacy delivery will be paid for the remaining days of the prescription up to 7 days.

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Annual fee increases are applied each February 1, based on the forecast of the Gross National Product (GNP) implicit price deflator, but not to exceed the increase approved by the North Carolina State Legislature. With the exception of nursing services, nursing supplies, and equipment, adjustments to the per diem fees may be made based on the provision of actual cost data.

There will be no retroactive payment adjustments for fee changes.

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8. Private duty nursing services. (PDN)

A. Private duty nursing services are reimbursed at the lower of billed customary charges or an established hourly rate. Effective October 1, 2002, this rate, is adjusted annually by the percentage change in the rate for a skilled nursing visit by a home health agency. Notwithstanding any other provision, if specified these rates will be adjusted as shown on Supplement 1 to the 4.19-B section of the state plan.

B. Effective October 1, 1993, payment for Private Duty Nursing Medical Supplies, except those related to provision and use of DME, shall be reimbursed at the lower of a provider's billed customary charges or the maximum fee established for certified home health agencies. The maximum amount for each item is determined by multiplying the prevailing Medicare Part B allowable amount by 145 percent to account for the allocation of overhead costs and by 80 percent to encourage maximum efficiency. Fees will be established based on average, reasonable charges if a Medicare allowable amount cannot be obtained for a particular supply item. The Medicare allowable amounts will be those amounts available to the Division of Medical Assistance as of July 1 of each year.

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9. Clinic Services

a. Payments will be based on negotiated fee, not to exceed reasonable cost

For services provided by or through the memorandum of understanding between the Department of Health and Human Services, Division of Medical Assistance and the Department of Environment and Natural Resources (DENR) a supplemental payment will be made between September 20, 1995 and September 30, 1995, in an amount which represents the difference between the estimated cost of services for the 12 month period ending September 30, 1995, and the estimate of payments made by the Division of Medical Assistance for these services. The amount of the supplement payment will be set by the Director of the Division of Medical Assistance and will not exceed $15,000,000. Effective with dates of services for the fiscal period beginning October 1, 1995, and for subsequent periods beginning October 1 an interim payment for services will be made by the Division of Medical Assistance. To assure payments do not exceed the upper payment limits set forth at 42 CFR 447.321, the payments made by this paragraph will be cost settled on a statewide average per service to determine the difference between the reasonable cost of services provided as determined by the Division of Medical Assistance and the amount of payment made for the services for each fiscal period corresponding to the payment periods specified. Cost settlements for the September 30, 1995, and September 30, 1996, fiscal period will occur within six (6) months after the approval date of this amendment, subsequent fiscal periods will be cost settled within six (6) months of the end of each fiscal period.

This cost methodology does not apply to the reimbursement of services which are billed by health departments for physicians, nurse midwives, and nurse practitioners who are not salaried employees of a health department and whose compensation is not included in the service cost of a health department. These services are reimbursed in accordance with the fees established in Section 5, Attachment 4.19-B.

Effective October 1, 2001 the cost settlement period shall be the twelve months ending June 30. The first settlement period after the change shall be short period from October 1, 2001 to June 30, 2002. Subsequent cost settlement periods shall be the twelve months ending June 30.

Effective July 1, 2001, the cost settlement shall occur within nine months of the end of the settlement period.

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b. Services provided by licensed kidney dialysis centers are reimbursed based on Medicare payment rates.

c. Services provided by licensed Ambulatory Surgical Centers are reimbursed based on the State average rates derived from ninety-five percent of the Medicare rates for routine facility services. Notwithstanding any other provision, if specified, these rates will be adjusted as shown on Attachment 4.19-B, Supplement 2, Page 1 of the State Plan.

d. Additional ancillary services, such as laboratory, x-ray and general anesthesia services, are reimbursed at the comparable fees paid to other providers.

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10. Dental services.

Payments for dental services shall be equal to the lower of the submitted charge or the appropriate fee from the fee schedule in effect on January 1, 1995, except for payments to the University of North Carolina Dental School which will be reimbursed at cost and cost settled at year end.

A. Annual fees are increased each January 1 based on the forecast of the Gross National Product (GNP) Implicit Price Deflator, but not to exceed the percentage increase granted by the North Carolina State Legislature.

B. For calendar year 2002 only, the Division of Medical Assistance shall increase dental fees based on access to care in lieu of inflationary increases.

C. Fees for new services are established based on the fees for similar existing services. If there are no similar services the fee is set at 75 percent of the estimated average charge.

D. Fees for services deemed to be associated with adequacy of access to health care services may be increased or decreased based on administrative review. The service must be essential to the health needs of the Medicaid recipients, no other comparable treatment available and a fee adjustment must be necessary to maintain dental participation at a level adequate to meet the needs of Medicaid recipients.

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12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

Multiple source and other drugs will be reimbursed at the lowest of: the estimated acquisition cost as described below plus a reasonable dispensing fee, the provider's usual and customary charge to the general public, the amount established by the North Carolina State determined upper payment limit plus a reasonable dispensing fee (this provision does not apply when there is only one enrolled pharmacy provider in the county), or the CMS upper limit plus a reasonable dispensing fee. A dispensing fee will not be paid for prescriptions refilled in the same month, whether it is the same drug or generic equivalent drug.

Multiple Source Drugs - North Carolina has implemented the list of drugs and their prices as published by the CMS and a State determined list of multiple source drugs. All drugs on this list are reimbursed at limits set by CMS or the State unless the physician writes in his own handwriting on the face of the prescription "brand necessary, dispense as written," or words of similar meaning.

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B. North Carolina Estimated Acquisition Cost (NCEAC)

NCEAC is defined as the reasonable and best estimate of the price paid by providers for a drug as obtained from a manufacturer or other legal distributor. As determined by the Division the reasonable and best estimate is based on the average wholesale price (AWP) less 10 percent. For the AWP information the Division uses the First Databank Price Update Service, manufacturer's price list, or other nationally published sources. Telephone contact with manufacturer or distributors may be utilized when a published source is not available.

C. Dispensing Fees

Dispensing fees are determined on the basis of surveys that are conducted periodically by Division of Medical Assistance (DMA) or other recognized sources and takes into account various pharmacy operational costs, such as salary, overhead, etc. Between surveys the dispensing fee may be adjusted based upon various factors, i.e., Consumer Price Index (CPI). The Division reviews the fees of the other states and other information (i.e., National Pharmacy Surveys). The dispensing fee is paid to all providers for the initial dispensing. Refills within the same month are not paid a dispensing fee. The dispensing fee is $5.60 for generic drugs and $4.00 for brand name drugs.

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D. Physician Drug Program

Effective January 1, 2006, the physician drug program will be reimbursed at the Average Selling Price plus 6% (ASP+6%) to follow Medicare pricing. If there is no ASP+6% value available from Medicare, fees shall be established based on the lower of vendor specific National Drug Code (NDC) ASP+6% pricing, Average Wholesale Price (AWP) - 10% pricing as determined using lowest generic product NDC, lowest brand product NDC or a reasonable value compared to other physician drugs currently on North Carolina's physician drug program list.

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12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Dentures.

Statewide fees for services will be established by using the prevailing Medicaid file in effect on July 1, 1981.

Fees for services will be established using the 75th percentile of usual and customary charges as identified in Medicaid's pricing file.

Fees will be set at 90 percent of the 75th percentile except when a General Dentist fee is higher than an Oral Surgeon's fee, and Oral Surgeons provide at least 10 percent of the services. In all such cases, both will be paid at the lower rate.

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12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in disease of the eye or by an optometrist.

12.c. PROSTHETIC AND ORTHOTIC DEVICES

Payment for each claim for prosthetic/orthotic devices will be equal to the lower of the supplier's usual and customary billed charges or the maximum fee established for each item. The maximum fees are set at 100 percent of the Medicare Part B fees as of January 1 of each year. If a Medicare fee cannot be obtained for a particular item, the fee will be based on estimates of reasonable costs and updated each January 1 by the forecasted percentage increase in prices for the devices. Notwithstanding any other provision, if specified these rates will be adjusted as shown on Supplement 4 to the Attachment 4.19-B section of the state plan. There will be no retroactive payment adjustments for fee changes.

When devices are provided by state or local government agencies, reimbursement will not exceed the cost of the device.

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12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

d. Eyeglasses.

Fees paid to dispensing providers are negotiated fees established by the State agency based on industry charges. Notwithstanding any other provision, if specified, these rates will be adjusted as shown on Attachment 4.19-B, Supplement 3, Page 1 of the State Plan.

Payment for materials is made to a contractor(s) in accordance with 42 CFR 431.54(d).

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13. OTHER DIAGNOSTIC SCREENING PREVENTIVE AND REHABILITATIVE SERVICES

Payments for other diagnostic screening, preventive and rehabilitative services provided by qualified providers are based on rates established by the Division of Medical Assistance for each type of mental health covered service. State developed fee schedule rates are the same for both public and private providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published on the DMA web-site.

Beginning July 1, 2004, the Division will establish prospective rates with all providers of mental health services. The initial prospective rates for HCSPCS Level II code (non-CPT code) mental health services will be established primarily based on 2002 cost report information, recognizing a 13% reduction in these rates to eliminate administrative costs included in mental health service rates in effect prior to July, 1, 2004. In addition, these HCSPCS Level II (non-CPT) code prospective rates for selected services will include increases for two years of inflation utilizing the GNP implicit price deflator. Inflationary increases will be made to these selected services to ensure sufficient providers of services are available to prevent accesses to care issues and to ensure that rates are reasonable.

Also, effective July 1, 2004, HCSPCS Level II (CPT code) mental health services will follow guidelines established for physician fee schedule services (4.19B, Section 5 Page 1). Rates can be adjusted to other than a physician fee schedule rate when it is determined that an access to care issue exists for a particular service. If services are provided by non-physician practitioners, rates will be reduced to a percentage of the physician fee schedule as outlined at 4.19B, Section 6. HCSPCS Level II (CPT code) rate services will be adjusted annually consistent with changes in the physician fee schedule rates.

With the implementation of the new enhanced services, October 1, 2005, as with well as any other new services which might be implemented subsequently, the Division will utilize various methodologies to determine appropriate reimbursement rates. Such methodologies will include cost modeling, an examination of what other states reimburse for identical or similar services or adjustment of current cost data to take into account the application of best practices as provided for in the new/revised mental health services.

Annual cost reporting will continue to be required of providers who provide mental health services subsequent to July 1, 2005 and will be used to ensure the rates for new as well as existing services continue to be reasonable and fair. Adjustments also will be made to the rates based on cost data in these cost reports.

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Reasonable costs are determined by the Division of Medical Assistance based upon the standards set in OMB Circular A-87 and the HCFA-15 Provider Reimbursement Manual. Notwithstanding any other provision, if specified these rates will be adjusted as shown on Supplement 1 to the 4.19-B section of the state plan.

The Division's determination of reasonable cost shall take into consideration only the cost of service related to providing Medicaid covered services. Rates shall be established at a level no greater than reasonable cost. Any costs related to non-Medicaid covered services shall be excluded from the rate determination process.

Prospective mental health service rates will not be cost settled.

[Note: The Division of Medical Assistance will complete cost settlement on the FY 2003 and FY 2004 expenditures in accordance with the State Plan in effect during those years. Settlement of FY 2003 and FY 2004 expenditures will be to a statewide average unit cost for each type of service and will be completed within six months of all the completed reports being received by the Division of Medical Assistance, but no later than June 30, 2006.]

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The services covered under this section are included under Attachment 3.1-A.1 of the state plan. These services are reimbursed on the basis of either a fee schedule or a per diem. Per Diem reimbursement methodologies for mental health bundled services are as detailed below. There are no payments for room, board or other administrative costs in inpatient psychiatric facilities, including facilities serving children under 21; reimbursement is for treatment costs only. No payments will be made to residents of IMDs, except for services provided to children under the age of 21 in inpatient psychiatric facilities meeting the requirements of 42 Code of Federal Regulations Part 441, Subpart D, and Part 483, Subpart G.

1) Substance Abuse Comprehensive Outpatient Treatment program (SACOT) (Adult – H2035)
Reimbursement rate is established by augmenting an existing service, Intensive Outpatient Services (IOP) rate by 33% to reflect more intensive treatment. The IOP service rate is an existing rate for outpatient therapy (individual/group/family) provided by licensed or certified mental health practitioners. The new rate consists of a weighted average of individual/ group/family therapy plus 2 hours of community support (based upon current utilization of case management) per week. The rate also includes salaries and fringe benefits for direct care staff and professional staff.

2) Intensive In-Home Services (Child – H2022)
Reimbursement rate is the established rate for this service reimbursed by North Carolina's SCHIP (Health Choice) program. The establishment of the reimbursement rate requires a minimum of two hours per day of outpatient therapy services (individual, family, case management) per service incident.

3) Medically Monitored or Alcohol Drug Addiction Treatment Center Detoxification/ Crisis Stabilization (Adult – H2036)
Reimbursement rates are determined on the basis of provider specific pro forma cost information. Providers submit cost templates and a reimbursement rate is established utilizing cost modeling. The cost model is based on agency estimates and is confirmed by input from at least three qualified providers. The cost model recognizes direct care service costs for staff salaries and fringe benefits. Direct care staff at the residential facility includes qualified, associate and paraprofessionals. Other direct service costs recognized include accreditation, communications, training, and travel costs. Facility overhead costs are recognized at 11% of total direct care service costs. A calculated per diem is determined by dividing total estimated days of service provided to recipients.

4) Substance Abuse Intensive Outpatient Program (Child and Adult – H0015)
Reimbursement rate is established by augmenting an existing service, Intensive Outpatient Services (IOP) rate by 26% to reflect more intensive treatment. The IOP service rate is an existing rate (based on 2002 cost findings submitted by mental health area programs reduced by 13% to remove overhead costs included in area program cost findings) for outpatient therapy (individual/group/family) provided by licensed or certified mental health practitioners. The new rate consists of a weighted average of individual/ group/family therapy plus 1.5 hours of community support (based upon current utilization of case management) per week. The rate also includes salaries and fringe benefits for direct care staff and professional staff.

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5) Substance Abuse Non-medical Community Residential Treatment – (Adult – H0012HB)
Reimbursement rate is based on a two-tiered level of treatment utilizing the SACOT rate discussed above. The rate is a single weighted average recognizing the two levels of treatment such that a more intense level of treatment is provided for the first 3 months and lower a lower level of treatment is provided for the next 6 months. The SACOT rate is modified to recognize five days of treatment per week with additional case management and community support requirements. Rates include costs for salaries and fringe benefits of direct care service workers, involving physicians, registered nurses, licensed practical nurses and certified clinical addiction specialists.

6) Substance Abuse Medically Monitored Community Residential Treatment (Adult – H0013)
Reimbursement rate is based on a two-tiered level of treatment utilizing the SACOT rate discussed above. The rate is a single weighted average recognizing the two levels of treatment such that a more intense level of treatment is provided for the first 3 months and lower a lower level of treatment is provided for the next 6 months. The SACOT rate is modified to recognize six days of treatment per week with additional case management and community support requirements. Rates include costs for salaries and fringe benefits of direct care service workers, involving physicians, registered nurses, licensed practical nurses and certified clinical addiction specialists.

7) Non Hospital Medical Detoxification (Adult – H0010)
Reimbursement rate is established utilizing cost modeling. The cost model is based on agency estimates and is confirmed by input from at least three qualified providers. The cost model, based on input from at least three qualified providers, recognizes direct care service costs for staff salaries and fringe benefits. Direct care staff includes registered nurses, health care technicians, substance abuse counselors as well as a physician. Facility overhead costs are calculated at 11% of total annual salaries and fringe benefits of direct care service staff.

8) Partial Hospital (Child and Adult – H0035)
Reimbursement rate is based on state fiscal year 2002 cost findings submitted by mental health area programs. Cost report data was inflated by 12% over a three year period to make cost data current and reduced by 13% to remove overhead costs included in area program cost findings.

9) Assertive Community Treatment Team (ACTT) (Adult – H0040)
Reimbursement rate is based on modifying an existing ACTT service to make it conform to the best practice model as approved by CMS. It requires at least four face to face contacts per month by team members. The model includes at a minimum; a qualified professional (QP), a nurse (RN), a physician (at least .25 FTEs per 50 clients), and paraprofessional staff who provide available 24 hour coverage. The new service model team members include an additional nurse (RN), a substance abuse specialist (CCS, LCAS, or CSAC), an administrative assistant/secretary, three additional QPs and increases physician hours by thirty percent. Rates include costs for salaries and fringe benefits of qualified professionals (QP), nurses (RN), physician, substance abuse specialists, administrative assistant/secretary and paraprofessional staff. The rate is a monthly rate divided by 4 (face to face contacts) to establish the per diem amount.

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The following services are billed in per 15 minute or per hour increments:

Diagnostic Assessment (Child and Adult - T1023)

Community Support/Child (H0036HA)

Psychosocial Rehabilitation/Adult (H2017)

Mobile Crisis Management (Child and Adult - H2011)

Community Support/Adult (H0036HB)

Community Support Team (Adult - H2015HT)

Mental Health Day Treatment/Child (H2012 HA)

Multi Systemic Therapy/Child (H2033)

Ambulatory Detoxification (Child and Adult - H0014)

Opioid Treatment (Adult – H0020)

Professional Treatment Services in Facility Based Crisis Programs (Adult – S9484)

The facilities providing these services are not IMD facilities.

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14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient Hospital Services.

Described in Attachment 4.19-A and Attachment 3.1-A.1, page 15b.

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14. Services for individuals age 65 or older in institutions for mental diseases.

C. Intermediate care facility services.

Described in Attachment 4.19-D.

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15.a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

Described in Attachment 4.19-D.

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15. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

b. Including such services in a public institution (or distinct part thereof for the mentally retarded or persons with related conditions.

Described in Attachment 4.19-D Addendum ICF-MR.

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16. Inpatient psychiatric facility services for individuals under 21 years of age.

Described in Attachment 4.19-A, Page 32 and Attachment 3.1-A.1, page 17.

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17. A. Nurse-midwife services.

Reimbursement will be made to licensed nurse-midwives enrolled in the North Carolina Medicaid program. Rates for procedure performed by nurse-midwives will be the same as the physician fee schedule. Billing will be accomplished via the standard physician billing form (HCFA-1500) using HCPCS coding.

B. Certified Registered Nurse Anesthetists Services (CRNA's).

Fees for certified registered nurse anesthetists (CRNA's) are established at 90% of Anesthesiology rates. For DMA approved procedures (CPT and HCPCS) CRNA's will be reimbursed the same as physician services, which are based on the current Physician Medicaid Fee Schedule.

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18. Hospice Care (in accordance with section 1905(o) of the Act).

Hospice services are paid using Medicare reimbursement rates and methodologies, adjusted to remove offsets for the Medicare co-insurance amounts, and with the following exceptions:

- There is no limit on overall aggregate payments made to a hospice agency by Medicaid.

- Payments to a hospice for inpatient care are limited in relation to all Medicaid payments to the agency for Hospice care. During the twelve month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days, inpatient respite and general inpatient, may not exceed 20 percent of the aggregate total number of days of Hospice care provided during the same time period for all the hospice's Medicaid patients. Hospice care provided for patients with acquired immune deficiency syndrome (AIDS) is excluded in calculating the inpatient care limit. The hospice refunds any overpayments to Medicaid.

- A hospice may be paid the appropriate long term care (SNF/ICF) room and board rate, in addition to the home care rate, for a nursing facility resident's Hospice care. The nursing facility may not bill Medicaid for the individual's care that duplicates Hospice Services.

- Notwithstanding any other provision, if specified, these rates will be adjusted as shown on Attachment 4.19-B, Supplement 2, Page 1 of the State Plan.

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19. Case Management Services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

a. Pregnant Women.

Case Management Services (Pregnant Women)

Reimbursement will be on a fee-for-service basis, billed monthly on the HCFA 1500 form. Payment will be the lesser of the charge or the established fee. The fee will be set by dividing the cost of an FTE case manager by the caseload size. The fee will be evaluated annually and any overpayments will be recouped in the following year's rate. The state will not pay more than cost. Notwithstanding any other provision, if specified, these rates will be adjusted as shown on Attachment 4.19-B, Supplement 1 section of the State Plan.

b. Adults and Children At-Risk For Abuse, Neglect, or Exploitation

Medicaid reimbursement for Case Management Services may not exceed cost. The interim per unit rate (One unit = fifteen minutes) will be determined annually by the Division of Medical Assistance. Notwithstanding any other provision, if specified, these rates will be adjusted as shown on Attachment 4.19-B, Supplement 1 section of the State Plan.

The payment each provider receives represents only the amount of federal Medicaid funding. This a amount is determined by multiplying the federal financial participation (FFP) rate in effect on the date of payment times the per unit rate. The FFP for the year October 1, 1992 to September 30, 1993 is 65.92%.

Each local provider must certify the availability of the matching non-federal share of service payments. This certification is required to be available for audit purposes and will be made in accordance with instructions provided by the Division of Social Services.

The interim rate will be subject to final settlement reconciliation with actual cost**.** Each provider must prepare and submit a report of its costs and other financial information related to reimbursement annually. The report must include costs from a fiscal period beginning on July 1 and ending on June 30 and must be submitted to the Division of Medical Assistance on or before the September 30 that immediately follows the June 30 year end.

State Plan Under Title XIX of the Social Security Act
Medical Assistance Program
State: North Carolina

Payments for Medical and Remedial Care and Services

c. Case Management (Chronically Mentally Ill, Severely Disabled Children, Chronic Substance Abuse and Developmental Disabilities)

For services provided by DMH/MR/SAS:

Payment for case management services is based on an hourly rate.
Effective with the 12 month period beginning July 1, 1999, and for subsequent 12 month periods, the rate paid is an interim amount that will be settled to cost. The interim rate is adjusted annually to equal the actual unit cost as determined in the cost analysis for the most recent year available. For payments to area mental health programs, cost determinations are based on weighted average unit cost for services as determined by the Division of Medical assistance. Reasonable costs are determined by the Division of Medical Assistance based upon the standards set in OMB Circular A-87 and the HCFA-15 Provider Reimbursement Manual. Notwithstanding any other provision, if specified, these rates will be adjusted as shown on Attachment 4.19-B, Supplement 1 section of the State Plan.

d. Case Management (Developmental Disabilities)

For services provided by DHS:

Reimbursement will be on a fee-for-service basis, billed monthly on the HCFA 1500 form. Payment will be the lesser of the charge or the established fee. The fee will be set by dividing the cost of an FTE case manager by the caseload size. The fee will be evaluated annually and any overpayments will be recouped in the following year's rate. The state will not pay more than cost. Notwithstanding any other provision, if specified, these rates will be adjusted as shown on Attachment 4.19-B, Supplement 1 section of the State Plan.

e. Case Management (Persons With HIV Disease)

Medicaid reimbursement for HIV case management services will be the same per unit rate (one unit equals fifteen minutes) for all providers. Providers will be reimbursed the lower of usual and customary charges or a negotiated rate basis which will not exceed the upper limitation of 42 CFR 447.325. Governmental providers will be paid based on the above-negotiated rate not to exceed actual costs. Notwithstanding any other provision, if specified, these rates will be adjusted as shown on Attachment 4.19-B, Supplement 1 section of the State Plan.

State Plan Under Title XIX of the Social Security Act
Medical Assistance Program
State: North Carolina

Payments for Medical and Remedial Care and Services

Payment for Personal Care, Home Health, Private Duty Nursing, and Rehabilitation Services:

FY 2003 – 5% reduction to Private Duty Nursing; No adjustment for other services.

FY 2005 and 2006 – No rate increase from the June 30, 2005 rate for all Medicaid private and public providers with the following exceptions: federally qualified health clinics, rural health centers, state institutions, outpatient hospital, pharmacy and the non-inflationary components of the case-mix reimbursement system for nursing facilities.

NC General Assembly legislation mandates that effective July 1, 2005, reimbursement rates for these programs (Personal Care, Home Health, Private Duty Nursing and Rehabilitation Services) for the state fiscal years 2005-2006 and 2006-2007 will remain at the rate in effect as of June 30, 2005, except rates may be adjusted downward.

Reference: Attachment 4.19-B, Section 23, Page 6; Section 7, Page 2; Section8, Page 1;
Section 12, Page 1; Section 19, Page 1 &2; and Section 20, Page 1

State Plan Under Title XIX of the Social Security Act
Medical Assistance Program
State: North Carolina

Payments for Medical and Remedial Care and Services

Payment for Home Infusion Therapy:

FY 2003 – No adjustment.

FY 2005 and 2006 – No rate increase from the June 30, 2005 rate for all Medicaid private and public providers with the following exceptions: federally qualified health clinics, rural health centers, state institutions, outpatient hospital, pharmacy and the non-inflationary components of the case-mix reimbursement system for nursing facilities.

NC General Assembly legislation mandates that effective July 1, 2005, reimbursement rates for these programs (Home Infusion Therapy) for the state fiscal years 2005-2006 and 2006-2007 will remain at the rate in effect as of June 30, 2005, except rates may be adjusted downward.

Reference: Attachment 4.19-B, Section 7, Page 5

MEDICAL ASSISTANCE
State NORTH CAROLINA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

20. Extended services to pregnant women.

a.) Pregnancy related and postpartum services for 60 days after the pregnancy ends; and

b.) **Services** for any other medical conditions that may complicate pregnancy.

The fee for childbirth and parenting classes is a negotiated rate of payment. Potential providers indicated participation was contingent upon establishing a fee that allowed them to recover their cost to provide the service. The reimbursement amount was established based on the current community practice of charging $60.00 per class series per client. This rate will be evaluated annually. **Notwithstanding any other provision, if specified these rates will be adjusted as shown on Supplement 1 to the Attachment 4.19-B section of the state plan.** In the case of a public agency, reimbursement determined to be in excess of cost will be recouped by means of a rate adjustment for the next year.

MEDICAL ASSISTANCE
State NORTH CAROLINA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

1. AMBULANCE-
Payment to private providers will not exceed customary charges which are reasonable, based on prevailing rates in the State. Notwithstanding any other provision, if specified these rates will be adjusted as shown on Attachment 4.19-B, Supplement 1, Page 2 of the state plan. Interim payment to public providers will be set at the same level as private providers and will be cost settled to equal the cost of services provided during the fiscal period beginning July 1, 1999 through June 30, 2000, and for subsequent 12 month fiscal periods. Cost will be determined by the Division of Medical Assistance by review of an annual cost finding in accordance with OMB Circular A-87 and the HCFA-15 Provider Reimbursement Manual. A statewide average cost for each type of transport will be developed and compared to the interim payment, based on this comparison, additional payment or recovery of payment will be made to assure that the total of payment equals cost.

2. MEDICALLY NECESSARY TRANSPORTATION OTHER THAN AMBULANCE-

(a) Unless ambulance transportation is needed as described in Rule 10 NCAC 26B .0110, County Departments of Social Services are responsible for providing medically necessary transportation: except, for clients who are residents of medical facilities and non-medical facilities. Medical facilities and non-medical facilities are responsible for medically necessary transportation for residents.

(b) Payments for medically necessary transportation shall be made in accordance with the provisions of 42 C.F.R. 434.12, which is incorporated by reference with subsequent changes and amendments. A copy of 42 C.F.R. 434.12 can be obtained from the Division of Medical Assistance at a cost of twenty cents (0.20) a copy.

3. CONTRACTS WITH PRIVATE NON-MEDICAL INPATIENT INSTITUTIONS-
The Division of Medical Assistance will enter into contracts using 42 CFR 434-12 for the provision of medically related patient transportation to and from other health care providers for State/County Special Assistance clients residing in domiciliary care homes.
Reimbursement is determined by the Division of Medical Assistance based on a capitation per diem fee derived from industry transportation cost with annual inflation adjustment. The rate may be recalculated from a cost reporting period selected by the state.

MEDICAL ASSISTANCE
State NORTH CAROLINA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

23. Any other medical care and any other type of remedial care recognized under State law, specified by, the Secretary.

d. Skilled nursing facility services for patients under 21 years age.

Described in Attachment 4.19-D.

MEDICAL ASSISTANCE
STATE NORTH CAROLINA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES
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23. Any other Medical Care and any other type of remedial care recognized under State law, specified by the Secretary.

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

Payment is based on an hourly fee not to exceed reasonable cost. Notwithstanding any other provision, if specified these rates will be adjusted as shown on supplement 1 to the 4.19-B section of the state plan.

CONTRACTS WITH PRIVATE NON-MEDICAL INPATIENT INSTITUTIONS

The Division of Medical Assistance shall enter into contracts using 42 CFR 434.12 for the provision of personal care services for State/County Special Assistance clients and those clients described in 42 CFR § 435.135 residing in adult care homes.

Reimbursement is determined by the Division of Medical Assistance based on a capitation per diem fee derived from review of industry costs and determination of reasonable costs with annual inflation adjustments. The initial basic per diem fee is based on one hour of services per patient day. Additional payments may be made utilizing the basic one hour per diem fee as a factor, for Medicaid eligibles that have a demonstrated need for additional care. The initial basic one hour fee is computed by determining the estimated salary, fringes, direct supervision and allowable overhead. Effective January 1, 2000 the cost of medication administration and personal care services direct supervision shall be added to the basic per diem. The per diem rates may be recalculated from a cost reporting period selected by the state. Notwithstanding any other provision, if specified these rates will be adjusted as shown on supplement 1 to the 4.19-B section of the state plan. Payments may not exceed the limits set in 42 CFR 447.361. Effective January 1, 2000, payments to private providers will be cost settled with any overpayment repaid to the Division of Medical Assistance. The first cost settlement period shall be the nine months ended September 30, 2000. Subsequently, the annual cost settlement period shall be the twelve months ending September 30. No additional payment will be made due to cost settlement.

CONTRACTS WITH PUBLIC NON-MEDICAL INPATIENT INSTITUTIONS

The Division of Medical Assistance shall enter into contracts using 42 CFR 447.200 for the provision of personal cares services for State/County Special Assistance clients and those clients described in 42 CFR § 435.135 residing in adult care homes.

Public providers will be paid on an interim basis using the same reimbursement methods applicable to private providers. Payments to public providers are to be cost settled with any overpayment repaid to the Division of Medical Assistance. No additional payment will be made due to cost settlement.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

STATE NORTH CAROLINA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Item.. VII Payment of Title XVIII Part A and Part B Deductible/Coinsurance

Except for a nominal recipient co-payment, if applicable, the Medicaid agency uses the following method:

	Medicare-Medicaid Individual		Medicare-Medicaid/QMB Individual		Medicare QMB Individual	
Part A Deductible	X	Limited to State Plan rates*	X	Limited to State Plan rates*	X	Limited to State Plan rates*
		Full amount		Full amount		Full amount
Part A Coinsurance	X	Limited to State Plan rates*	X	Limited to State Plan rates*	X	Limited to State Plan rates*
		Full amount		Full amount		Full amount
Part B Deductible	X	Limited to State Plan rates*	X	Limited to State Plan rates*	X	Limited to State Plan rates*
		Full amount		Full amount		Full amount
Part B Coinsurance	X	Limited to State Plan rates*	X	Limited to State Plan rates*	X	Limited to State Plan rates*
		Full amount		Full amount		Full amount

*For these title XVIII services not otherwise covered by the title XIX State plan, the Medicaid agency has established reimbursement methodologies that are described in 4.19-B, Item(s)_____

REIMBURSEMENT FOR INDIAN HEALTH SERVICE
AND TRIBAL 638 HEALTH FACILITIES

Payment for services to Indian Health Service and Tribal 638 Health Facilities is based upon the amounts as determined and published in the Federal Register by the United States Government for these providers.

MEDICAL ASSISTANCE
State: NORTH CAROLINA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

Payment for Personal Care, Home Health, Private Duty Nursing, and Rehabilitation Services:

FY 2003 – 5% reduction to Private Duty Nursing; No adjustment for other services.

Reference: Supplement to Attachment 4.19-B amendments 02-09, 02-10, 02-11 and 02-12

State Plan Under Title XIX of the Social Security Act
Medical Assistance Program
State: North Carolina

Payments for Medical and Remedial Care and Services

Payment for Personal Care for Adult Care Homes, Transportation, Medical Equipment, and Ambulatory Surgical Centers:

FY 2003 – No adjustment.

FY 2004 – No adjustment for Durable Medical Equipment effective August 1, 2003.

– No adjustment for Personal Care for Adult Care Homes, Transportation and Ambulatory Surgical Centers effective October 1, 2003.

FY 2005 and 2006 – No rate increase from the June 30, 2005 rate for all Medicaid private and public providers with the following exceptions: federally qualified health clinics, rural health centers, state institutions, outpatient hospital, pharmacy and the non-inflationary components of the case-mix reimbursement system for nursing facilities.

NC General Assembly legislation mandates that effective July 1, 2005, reimbursement rates for these programs (Personal Care of Adult Care Homes, Transportation, Medical Equipment and Ambulatory Surgical Centers) for the state fiscal years 2005-2006 and 2006-2007 will remain at the rate in effect as of June 30, 2005, except rates may be adjusted downward.

Reference: Attachment 4.19-B, Section 23, Page 6; Section 23, Page 1;
Section 7, Page 4; Section 18, Page 1, and Section 9, Page 2.

State Plan Under Title XIX of the Social Security Act
Medical Assistance Program
State: North Carolina

Payments for Medical and Remedial Care and Services

Payment for Physician Fees**,** Personal Care Services (Community Based) and Eyeglasses:

FY 2004 – No adjustment. {Physician Fees and Personal Care Services (Community Based)}

FY 2005 and 2006 – No rate increase from the June 30, 2005 rate for all Medicaid private and public providers with the following exceptions: federally qualified health clinics, rural health centers, state institutions, outpatient hospital, pharmacy and the non-inflationary components of the case-mix reimbursement system for nursing facilities.

NC General Assembly legislation mandates that effective July 1, 2005, reimbursement rates for these programs (Physician Fees and Eyeglasses) for the state fiscal years 2005-2006 and 2006-2007 will remain at the rate in effect as of June 30, 2005, except rates may be adjusted downward.

Reference: Attachment 4.19-B, Section 5, Page 1; Section 12, Page 4; and Section 23 Page 6

State Plan Under Title XIX of the Social Security Act
Medical Assistance Program
State: North Carolina

Payments for Medical and Remedial Care and Services

Payment for Orthotics and Prosthetics:

FY 2004 – No adjustment.

FY 2005 and 2006 – No rate increase from the June 30, 2005 rate for all Medicaid private and public providers with the following exceptions: federally qualified health clinics, rural health centers, state institutions, outpatient hospital, pharmacy and the non-inflationary components of the case-mix reimbursement system for nursing facilities.

NC General Assembly legislation mandates that effective July 1, 2005, reimbursement rates for these programs (Orthotics and Prosthetics) for the state fiscal years 2005-2006 and 2006-2007 will remain at the rate in effect as of June 30, 2005, except rates may be adjusted downward.

Reference: Attachment 4.19-B, Section 12, Page 3